

ASSOCIATES REHABILITATION, INC.

Subject: Personnel Files/Requirements

Dear Applicant:

Please complete all documents hereby attached and send via fax to 305-552-9953 or mail at 13238 SW 8 Street, Miami, FL 33184

Policy Statement: A personal file will be kept on each employee to comply with all applicable Federal, State and Local Laws.

Purpose:

To delineate what is retained in the personnel file.

Procedure:

In order to keep accurate records of the employee's qualification, the facility must keep current photocopies of certain documents such as:

- Professional License
- Graduate Diploma if available
- Professional Liability Insurance
- CPR Certification
- Continuing Education Diploma including HIV/OSHA/Domestic Violence and Medical Error Prevention current
- US Work Permit/Voter's Card/Residency
- Social Security
- Driver's License
- Current Physical examination with TB Testing within 6 months

Furthermore, the following documents will be required for all personnel:

- Application and Resume
- Two Professional Reference Letters
- Job Description Signed
- Contractual Agreement
- Completed W-9
- Completed I-9 INS Form
- Signed Confidentiality Statement
- Signed Orientation Manual/Policy Statement

Employees are sent a reminder in the month prior to expiration of a particular document. Failure to maintain a current file could result in disciplinary procedure or termination.

ASSOCIATES REHABILITATION, INC.

Application for Employment - Equal Opportunity Employer

Applicant's Name: _____ Date: _____

Address: _____

Tel: _____ Mob: _____ Email: _____

Position desired: _____ Date you can start: _____

Salary desired: _____ Are you employed now: _____

Education History:

Only list schools where you obtained your PT/OT/PTA/COTA Diploma and date of attendance.

Name of School: _____ City, State: _____

Attendance from: _____ to: _____ Major: _____

Name of School: _____ City, State: _____

Attendance from: _____ to: _____ Major: _____

Employment History:

Only list employments related to your position.

From: _____ To: _____ Position: _____

Company's Name: _____ Tel: _____

Address: _____

May we contact this employer for references: ()YES ()NO

From: _____ To: _____ Position: _____

Company's Name: _____ Tel: _____

Address: _____

May we contact this employer for references: ()YES ()NO

From: _____ To: _____ Position: _____

Company's Name: _____ Tel: _____

Address: _____

May we contact this employer for references: ()YES ()NO

From: _____ To: _____ Position: _____

Company's Name: _____ Tel: _____

Address: _____

May we contact this employer for references: ()YES ()NO

Personal References:

Name: _____ Tel: _____

Address: _____

Name: _____ Tel: _____

Address: _____

Name: _____ Tel: _____

Address: _____

Authorization

I Certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissals.

I also hereby authorized this employer to verify all information included in this application, including references, previous employment and education history.

Signature: _____ Date: _____

Associates Rehabilitation, Inc.
Tel: 305-552-9505 Fax: 305-552-9953

13238 SW 8 St
Miami, FL 33184

REFERENCE REQUEST FORM

To: _____ Date: _____

Regarding:

Employee Name: _____ SS #: _____

Dates of employment: _____

I have made application for employment with above listed employer. I hereby request and authorize you to furnish the above listed employer with any information concerning my employment record, character, habits and ability. I do hereby release the addressed entity and all individuals concerned for any claims, suits, and liabilities for any damage whatsoever resulting from their actions and conduct in responding to this request and the giving of such information.

Applicant's Signature: _____

To be completed by previous employer

What were the applicant's responsibilities? _____

Please rate the applicant's performance in the following areas:
E=Excellent A=Average U=Unsatisfactory

Area	Rate	Area	Rate
Attendance/Punctuality		Cooperation/Team Work	
Job Knowledge/Skills		Initiative	
Productivity		Reliability	
Quality of Work		Attitude	

Additional comments: _____

Completed by: _____ Date: _____

ASSOCIATES REHABILITATION, INC.

New Employee Acknowledgement Form

Please fill out the following information clearly and completely so that we may properly activate your personnel file.

Name: _____ SS: _____

Emergency Contact:

In case of an Emergency we may need to contact someone from your choice. Please list a contact for emergency contact:

Name: _____ Tel: _____

Address: _____

Confidentiality Statement:

I have been formally instructed regarding the Clinic Policies and Procedures and HIPPA guidelines for maintaining confidentiality of all information contained in client/personnel files and records, as well as any other proprietary information regarding the Agency that is obtained verbally.

I understand that any breach of Confidentiality may be grounds for immediate termination of employment.

Notification of Introductory Period:

I have been informed that is the policy of the Agency to have a 90 days introductory period. If for any reason, employment is terminated during this period, I understand and accept that this account will not be charged with any unemployment benefits I may be eligible to receive under the State Unemployment Compensation Law.

I also understand and accept, that at the end of the 90 days period, I will receive a written evaluation of my work performance.

Acknowledgement of Employee Policy and Procedure Manual/Orientation:

I hereby acknowledge that I have read and understand the Employee Policy and Procedure Manual. I have also received an orientation to all Administrative, Patient Care Policies, Infection Control Policies, Safety and Risk Management, and I am familiar with the procedures appropriate to my position.

Employee Signature: _____ Date: _____

ASSOCIATES REHABILITATION, INC.

ORIENTATION CHECKLIST

Employee Name: _____

Title: _____

Orientation Date: _____

I hereby verify that I have received orientation to the facility in the form of both verbal and written information. The following topics were covered.

- Facility's Organizational Structure
- Location of emergency exits/lights/fire extinguishers/first aid box/emergency evacuation routes.
- Standards of Ethical Conduct
- Scope of Services/Patient Care Policies
- Employment Policies and Job Description
- Compliant Policy/Grievance
- Facility Policies and Procedures including but not limited to:
 - Patient Care Policies
 - OSHA/Universal Precautions
 - HIPAA/Protection and Release of Protected Health Information
 - Bio Medical Waste Program/Management
 - Care of Environment/Equipment
 - Disaster Preparedness/Fire Drill Training
- Clinical Records Documentation
- Office Policies

I _____, have read and understand the policies and procedures for this facility and have had the opportunity to have all of my questions answered to my satisfaction. I agree to abide by established policies and procedures, and I understand that failure to do so may be grounds for termination of employment.

I also understand that I am required to provide this facility with 14 days written advance notice of intent to terminate employment.

Employee Signature

Date

Affidavit of Good Moral Character

County of Dade, State of Florida

Before me this day personally appeared _____ who,
being duly sworn, deposes and says:

As an applicant for employment with: *Associates Rehabilitation, Inc.*

I hereby attest to meeting the requirements for employment, that I am of good moral character, that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense prohibited under any of the following provisions of Florida Statutes or any under similar statute of another jurisdiction:

- (a) Section 415.111 relating to abuse, neglect, or exploitation of aged or disabled adults
- (b) Section 782.04 relating to murder
- (c) Section 782.07 relating to manslaughter
- (d) Section 781.071 relating to vehicular homicide
- (e) Section 782.09 relating to killing an inborn child by injury to the mother.
- (f) Section 784.011 relating to assault if the victim was a minor.
- (g) Section 784.021 related to aggravated assault
- (h) Section 784.03 relating to battery if victim was a minor
- (i) Section 784.045 related to aggravated battery
- (j) Section 784.01 related to kidnapping
- (k) Section 787.02 related to false imprisonment
- (l) Section 794.011 related to sexual battery
- (m) Section 794.041 relating to prohibited acts of person in familiar or custodial authority.
- (n) Chapter 796 relating to prostitution
- (o) Section 798.02 relating to lewd and lascivious behavior.
- (p) Chapter 800 relating to lewd and lascivious behavior.
- (q) Section 806.01 relating to arson.
- (r) Chapter 812 relating to theft, robbery, and related crimes if a felony
- (s) Section 817.5463 relating to fraudulent sale of controlled substances only if the offense was a felony
- (t) Section 826.04 relating to incest
- (u) Section 827.03 relating to aggravated child abuse.
- (v) Section 827.04 relating to abuse
- (w) Section 827.05 relating to negligent treatment of children.
- (x) Section 827.071 relating to sexual performance by a child
- (y) Chapter 847 relating to obscene literature
- (z) Chapter 893 relating to drug abuse prevention and control, if a felony

I further attest, that I have not been judicially determined to have committed abuse or neglect against a child as defined in s.39.01(2) and (37), Florida Statutes; nor do I have confirmed report of adult abuse, neglect, or exploitation as defined in s.415.102(5), or abuse or neglect as defined in s.415.503(6), which has been uncontested or upheld under s.415.103 or s.415.504, Florida Statutes; nor have I committed an act which constitutes a domestic violence as defined in s.741.30.

Under the penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true to the best of my knowledge and belief.

Affiant

Or

To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts of offenses.

Affiant

Sworn to and subscribed before me this _____ day of _____ of _____.

Notary Public Stamp:

Notary Public Signature

Associates Rehabilitation, Inc.

Hepatitis B Vaccination Declination

I, _____, decline vaccination for the Hepatitis B Vaccine.

By doing so, I understand that due to my occupation's exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand, that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I choose to be vaccinated with the Hepatitis B vaccine, I can receive the vaccine series at no charge at that time.

Employee Signature: _____ Date: _____

Employee Health Release for TB Signs and Symptoms

I understand that as part of my condition for employment, I am required to be screened for TB annually through a PPD test or a chest x-ray if a past positive result was obtained.

The early signs and symptoms of tuberculosis are as follows:

- Cough, night sweats, fever, loss of weight, loss of appetite, coughing blood

I have read the above information and do not now have these symptoms. If these symptoms develop, I will contact my supervisor immediately for follow up.

Employee Signature: _____ Date: _____

Physical Examination Form

Employee Name: _____

In my opinion, the above employee is physically and mentally able to perform his job duties, is free of communicable disease, and does not constitute a risk of communicating disease to any person under the care of the agency.

Physician's (Signature)

Date

Physician Name (Print)

Street Address

City, State, Zip

TUBERCULIN SKIN TEST

Test Date: _____

Type: _____

Reading Date: _____

Positive: _____ Negative: _____

Recommendations:

Associates Rehabilitation, Inc.

Subject: Job Description

Title: Physical Therapist

Reports to:

Administrator

Job Summary:

Is a professional member of the rehabilitation team who acts as the team leader, who evaluates patients following referring Physician's orders, assists in the development of the Plan of Care and is responsible for the deliverance of professional physical therapy treatment and procedures designed to restore the patient/client to his maximum level of functioning.

Education/Experience and Qualifications:

1. Is a person who is licensed as a physical therapist in the State of Florida.
2. Has graduated from a physical therapy curriculum approved by:
 - a. The American Physical Therapy Association, or
 - b. The Committee on Allied Health Education and Accreditation of the American Medical Association, or
 - c. The Council on Medical Education of the American Medical Association and the American Physical Therapy Association, or
 - d. Prior to January 1, 1966:
 - i. Was admitted to membership by the APTA association, or
 - ii. Was admitted to registration by the American Registry of Physical Therapists
 - iii. Has graduated from a physical therapy curriculum in a 4 year college or university approved by the State of Florida department of education, or
 1. Has 2 years experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977, or
 2. Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970 had 15 years of full time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy

- e. If trained outside the United States:
 - i. Was graduated since 1928 from a PT curriculum approved in the country in which the curriculum was located and in which here is a member organization of the World Confederation for Physical Therapy.
 - ii. Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy
 - f. Minimum of two years experience within the health care community.
3. Patient/Client Care Responsibilities:
- a. Conduct a comprehensive patient evaluation, administering test and measurement of strength, ROM, and ADL's, balance, posture and other tests individualized based upon each patient's needs.
 - b. Establish a written Plan of Care indicating the type, amount, frequency and duration of treatment.
 - c. Provide services using therapeutic exercise, and modalities and other standard physical therapy procedures.
 - d. Re-Evaluates patients as needed to measure progress towards goals and medical necessity.
 - e. Is present or readily available to offer supervision when a physical therapists assistant furnishes services.
 - f. Complete discharges summaries to forward to referring physician at the end of the treatment cycle.
 - g. Complies with all applicable laws and regulations
 - h. Communicates with other health team members and physicians as needed to discuss patient's progress, need of modification of treatment, and other information needed.
 - i. Complies with Infection Control, Confidentiality and all other Patient Care Policies and procedures.
 - j. Conducts self in a professional manner at all times, at all places.

Documentation Requirement:

- 1. Insures that documentation is comprehensive, complete, accurate and legible.
- 2. Insures that documentation is completed in a timely manner.
- 3. Follows facility's guidelines for documentation.
- 4. Insures that documentation is date and signed or countersigned (when applicable) with name, title and license no.

Professional Responsibilities:

- 1. Knows and supports laws, regulation and agency's policies and procedures related to professional activity, accepts responsibility and is accountable for the same.
- 2. Demonstrates professional behavior
- 3. Participates in Agency's orientation, in-service and quality assurance activities.
- 4. Acts as a case manager for patients receiving Physical Therapy under his/her care.
- 5. Acts as resource person.

6. Understands professional limitations and seeks or accepts assistance, as necessary.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/or experience to carry out these duties.

Employee Signature

Date

Associates Rehabilitation, Inc.

Subject: Job Description

Title: Occupational Therapist

Reports to:

Administrator

Job Summary:

Is a professional member of the rehabilitation team who acts as the team leader, who evaluates patients following referring Physician's orders, assist in the development of the Plan of Care and is responsible for the deliverance of professional occupational therapy treatment and procedures designed to restore the patient/client to his maximum level of functioning.

Education/Experience and Qualifications:

1. Is a person who is licensed as a physical therapist in the State of Florida.
2. Has graduated from a occupational therapy curriculum with a bachelor's degree approved by The American Occupational Therapy Association and the Committee on Allied Health Education and Accreditation of the American Medical Association
3. Successful completion of National Examination for registered occupational therapists (OTR)
4. Has completed certification for use of Ultrasound and other modalities as required by the AOTA.
 - If trained outside the United States:
 - i. Was graduated from an OT curriculum approved in the country in which the curriculum was located and approved by AOTA.
5. Minimum of two years experience within the health care community.

Patient/Client Care Responsibilities:

- a. Conduct a comprehensive patient evaluation administering test and measurement of strength, ROM, and ADL's, balance, posture and other tests individualized based upon each patient's needs.
- b. Establish a written Plan of Care indicating the type, amount, frequency and duration of treatment.
- c. Provide services using therapeutic exercise, and modalities and other standard physical therapy procedures.
- d. Re-Evaluates patients as needed to measure progress towards goals and medical necessity.
- e. Is present or readily available to offer supervision when an occupational therapists assistant furnishes services.
- f. Complete discharges summaries to forward to referring physician at the end of the treatment cycle.
- g. Complies with all applicable laws and regulations

- h. Communicates with other health team members and physicians as needed to discuss patient's progress, need of modification of treatment, and other information needed.
- i. Complies with Infection Control, Confidentiality and all other Patient Care Policies and procedures.
- j. Conducts self in a professional manner at all times, at all places.

Documentation Requirement:

- 1. Insures that documentation is comprehensive, complete, accurate and legible.
- 5. Insures that documentation is completed in a timely manner.
- 6. Follows facility's guidelines for documentation.
- 7. Insures that documentation is date and signed or countersigned (when applicable) with name, title and license no.

Professional Responsibilities:

- 7. Knows and supports laws, regulations and facility's policies and procedures related to professional activity, accepts responsibility and is accountable for the same.
- 8. Demonstrates professional behavior
- 9. Participates in Agency's orientation, in-service and quality assurance activities.
- 10. Acts as a case manager for patients receiving Occupational Therapy under his/her care.
- 11. Acts as resource person.
- 12. Understands professional limitations and seeks or accepts assistance, as necessary.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/or experience to carry out these duties.

Employee Signature

Date

Associates Rehabilitation, Inc.

Subject: Job Description/Medical Social Worker

Title: Licensed Medical Social Worker

Reports to:

Administrator

Job Summary:

Is a professional member of the rehabilitation team who deliver services that are designed to enhance the physical, emotional and psycho-social needs of the patient as assigned and in accordance with the physician order.

Education/Experience and Qualification

1. Is a person who is licensed as a medical social worker in the State of Florida.
2. Has graduated from an accredited school by the Council on Social Work Education with a master degree.
3. Has one year experience in social services in the health care community

Patient/Client Care Responsibilities:

- Assist the physician and other members of health in team in understanding significant social and emotional factors related to the patient's health problems.
- Assess the social and emotional factors in order to estimate the patient's capacity and potential to cope with problems of daily living.
- Helps the patient and family to understand, accept and follow medical recommendations and provide services planned to restore the patient to optimum social and health adjustment.
- Assist the patients and families with personal and environmental difficulties which predisposed toward illness or interfere with obtaining maximum benefits from medical care.
- Identify resources, such as family and community agencies, to assist the patient to resume life in the community or to learn to live within his disability.
- Provides clinical counseling to patients or family members (only if licensed pursuant to Chapter 491, F.S. Specific Authority: 400.497, FS
- Complies with all applicable laws and regulations
- Communicates with other health team members and physicians as needed to discuss patient's progress, need of modification of treatment, and other information needed.
- Complies with Infection Control, Confidentiality and all other Patient Care Policies and procedures.
- Conducts self in a professional manner at all times, at all places.

Documentation Requirement:

1. Insures that documentation is comprehensive, complete, accurate and legible.
2. Insures that documentation is completed in a timely manner.
3. Follows facility's guidelines for documentation.
4. Insures that documentation is date and signed or countersigned (when applicable) with name, title and license no.

Professional Responsibilities:

1. Knows and supports laws, regulation and agency's policies and procedures related to professional activity, accepts responsibility and is accountable for the same.
2. Demonstrates professional behavior
3. Participates in Agency's orientation, in-service and quality assurance activities.
4. Acts as a case manager for patients receiving Social services under his/her care.
5. Acts as resource person.
6. Understands professional limitations and seeks or accepts assistance, as necessary.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/or experience to carry out these duties.

Employee Signature

Date

Associates Rehabilitation, Inc.

Subject: Job Description

Title: Physical Therapist Assistant

Reports to:

Administrator

Job Summary:

Is a professional member of the rehabilitation team who delivers professional physical therapy treatment and procedures designed to restore the patient/client to his maximum level of functioning.

Education/Experience and Qualifications:

- Is a person who is licensed as a physical therapist assistant in the State of Florida.
- Has graduated from a two-year college physical therapy curriculum approved by The American Physical Therapy Association.
- Has two year of appropriate experience as a Physical Therapist Assistant

Patient Care Responsibilities:

- Provides care consistent with physical therapy assistant professional standards and applicable laws and regulations.
- Uses appropriate interventions to meet physical, psychosocial, environmental and safety needs of patient/client and family.
- Uses teaching methods as appropriate, including demonstration, verbal and written instructions
- Provides Care compliant with all agency's policies and procedures.
- Communicates with referring physician, clinical director, case manager and other members of the Health Care Team as necessary and according to the Agency's Policies and Procedures.
- Provides continuity of care and high quality of services
- Consults with Registered Physical Therapist in charge as often as necessary and at least every once a month.
- Reports significant changes in the level of function of the patient as soon as possible to case manager.
- Provides physician/insurance progress reports when requested.

Documentation Responsibilities:

- Completes documentation in a comprehensive, legible, accurate way and signs and includes license number on all documentation.
- Completes documentation in a timely manner.
- Complies with agency's policies and procedures on documentation.

Professional Responsibilities:

- Knows and supports laws, regulation and agency's policies and procedures related to professional activity, accepts responsibility and is accountable for the same.
- Demonstrates professional behavior
- Participates in Agency's orientation, in-service and quality assurance activities.
- Acts as a case manager for patients receiving Social services under his/her care.
- Acts as resource person.
- Understands professional limitations and seeks or accepts assistance, as necessary.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/or experience to carry out these duties.

Employee Signature

Date

Associates Rehabilitation, Inc.

Subject: Job Description

Title: Certified Occupational Therapist Assistant

Reports to:

Administrator

Job Summary:

Is a professional member of the rehabilitation team who delivers professional occupational therapy treatment and procedures designed to restore the patient/client to his maximum level of functioning.

Education/Experience and Qualifications:

- Is a person who is licensed as an occupational therapist assistant in the State of Florida.
- Has graduated from a two-year college physical therapy curriculum approved by The American Occupational Therapy Association.
- Has two year of appropriate experience as an Occupational Therapist Assistant

Patient Care Responsibilities:

- Provides care consistent with occupational therapy assistant professional standards and applicable laws and regulations.
- Uses appropriate interventions to meet physical, psychosocial, environmental and safety needs of patient/client and family.
- Uses teaching methods as appropriate, including demonstration, verbal and written instructions
- Provides Care compliant with all agency's policies and procedures.
- Communicates with referring physician, clinical director, case manager and other members of the Health Care Team as necessary and according to the Agency's Policies and Procedures.
- Provides continuity of care and high quality of services
- Consults with Registered Occupational Therapist in charge as often as necessary and at least every once a month.
- Reports significant changes in the level of function of the patient as soon as possible to case manager.
- Provides physician/insurance progress reports when requested.

Documentation Responsibilities:

- Completes documentation in a comprehensive, legible, accurate way and signs and includes license number on all documentation.
- Completes documentation in a timely manner.
- Complies with agency's policies and procedures on documentation.

Professional Responsibilities:

- Knows and supports laws, regulation and agency's policies and procedures related to professional activity, accepts responsibility and is accountable for the same.
- Demonstrates professional behavior
- Participates in Agency's orientation, in-service and quality assurance activities.
- Acts as a case manager for patients receiving Social services under his/her care.
- Acts as resource person.
- Understands professional limitations and seeks or accepts assistance, as necessary.

By my signature, I acknowledge and accept the responsibilities of this position. I am qualified by education and/or experience to carry out these duties.

Employee Signature

Date

Associates Rehabilitation, Inc.

Agreement to Provide Sub-Contracted Services

This agreement is made and entered into this _____ Day of _____, 20____, by and between **Associates Rehabilitation, Inc.** and:

_____(Contracted employee)
(Name, Credentials, License number).

The purpose of this agreement is to provide _____ services on **Associates Rehabilitation, Inc** premises for the rehabilitation of injured, disabled or sick persons that receive therapeutic and restorative care by **Associates Rehabilitation, Inc**

Associates Rehabilitation, Inc retains all professional and administrative responsibility for, and control and supervision of the services provided under this agreement.

The contracted employee **may not bill** the patient, Medicare or any other insurance for the services provided under this agreement. This limitation is based on section 1861(w)(1) of the Act, which provides that:

- Only the provider may bill the beneficiary for covered services furnished under arrangements; and
- Receipt of Medicare payment by the provider, on behalf of an entitled individual, discharges the liability of the individual or any other person to pay for those services.

The services will be provided on a contract basis with the contracted employee being paid for the specific number of hours worked or treatment given. **Associates Rehabilitation, Inc** will pay the contracted employee, upon receipt of a statement of services rendering during the previous period a fee of \$_____per hour or treatment.

Personnel Requirement:

Sub-contracted employees must meet all the requirements specified in the Job Description hereby attached.

Sub-Contractor Duties and responsibilities:

The duties and responsibilities of the contracted employee are those contained in the Job Description, attached here with and selected Policies and Procedures of **Associates Rehabilitation, Inc.** The condition of participation polices for **Associates Rehabilitation, Inc** has been provided here upon signing of this Agreement.

The contracted employee shall perform his/her work in accordance with the currently approved methods and practice of his Professional Association.

The contracted employee shall:

- Follow all Policies and Procedure of the agency.
- Provide all records, reports, evaluations and progress notes in **Associates Rehabilitation, Inc** Format
- Complete records in a timely manner
- Follow all **Associates Rehabilitation, Inc** documentation guidelines
- Report to Clinical Director
- Comply with the Civil Rights Act of 1964 (Title VI) to the end that he/she will not discriminate against any patients on grounds of race, color, national origin, sex preference, religion or handicap.

The validity of this agreement and any of the terms of provisions as well as the rights and duties of the parties hereunder shall be governed by the Laws of the USA Federal Government and the State of Florida.

This agreement may be amended by the mutual agreement of the parties hereto in a writing to be attached to and incorporated into this agreement.

In case of any one or more of the provisions contained in this agreement shall for any reason be held to invalid, illegal or unenforceable in any respective, such invalidity, illegality or unenforceable shall not affect any other provision thereof and no other agreement, statement, or promise relating to the subject of the matter of this agreement which is not contained herein, shall be valid or binding.

This agreement shall continue and be binding upon both parties unless terminated as herein provided for ___ year(s), at which time it will be reviewed. It may be terminated at any time by either party upon (30) days advanced written notice to the other party.

This contract shall be terminated by the _____ day of _____, 20____.

Associates Rehabilitation, Inc

Date

Signature of Sub-Contracted Employee

Date